STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155446	A. BUILDING 01 B. WING _____	02/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVINGTON MANOR HEALTH AND REHABILITATION CENTER	5700 WILKIE DRIVE FORT WAYNE, IN 46804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 02/08/11 Facility Number: 000476 Provider Number: 155446 AIM Number: 100290870 Surveyor: Amy Kelley, Life Safety Code Specialist At this Life Safety Code survey, Covington Manor Health and Rehabilitation Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies, Chapter 18, New Health Care Occupancies in the Rehabilitation Center and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in corridors and areas open to the corridors. The facility has a capacity of 149 and had a census of 132 at the time of this survey. Quality Review by Robert Booher, REHS, Life Safety Code Specialist-Medical Surveyor on 02/11/11. The facility was found not in compliance with the	K 000	RECEIVED MAR - 1 2011 LONG TERM CARE DIVISION INDIANA STATE DEPARTMENT OF HEALTH	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Director — (X6) DATE: 2/25/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

APPROVED 3/4/11

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K 000	Continued From page 1 aforementioned regulatory requirements as evidenced by the following:	K 000		
K 056 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: 1. Based on observation and interview, the facility failed to ensure 1 of 5 skilled unit corridors and 1 of 1 kitchens were equipped with one type of sprinkler head, i.e., quick response sprinklers or standard sprinklers. NFPA 13, 1999 Edition, Installation of Sprinkler Systems, 5-3.1.5.2 states when existing light hazard systems are converted to use quick response or residential sprinklers, all sprinklers in a smoke compartment shall be changed. This deficient practice could affect 27 residents in the 300 hall and any number of kitchen staff. Findings include: Based on observations with the Maintenance Director on 02/08/11 from 12:40 p.m. to 1:25	K 056	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* K 056 1. All sprinkler heads identified in the 300 hall and kitchen were replaced to match. The identified sprinkler head in the dryer room was brought to code, 2. All facility sprinkler heads were reviewed to ensure there were not a mixtures of sprinkler heads types in any one smoke compartment 3. Sprinkler heads will be reviewed quarterly with the contracted inspections to ensure there is not mixture in type of heads. 4. Results of this audit will be brought to QA for tracking and trending quarterly for one year then annually thereafter. 5. March 10th, 2011	

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K 056	Continued From page 2 p.m., the kitchen and the 300 hall in the area leading to the rehabilitation unit had a mixture of quick response sprinkler heads and standard response sprinkler heads. Based on interview with the Maintenance Director, the sprinkler company was in the process of changing the sprinkler heads in the kitchen. Additionally, the quick response sprinkler heads were located in the short corridor off the 300 hall leading to the newly constructed Rehabilitation unit. 3.1-19(b) 2. Based on observation and interview, the facility failed to install 2 of 2 sprinkler heads in the dryer side of the Laundry room in accordance with NFPA 13, Section 5-6.3.4 which requires sprinklers be located no closer than six feet measured on center. This deficient practice could affect all staff in or near the laundry room in the event of an emergency. Findings include: Based on an observation with the Maintenance Director on 02/08/11 at 1:15 p.m., the dryer side of the Laundry room had two sprinklers located two and one half feet apart. This was acknowledged by the Maintenance Director at the time of observation.	K 056		
K 130 SS=E	3.1-19(b) NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786	K 130		

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K 130	Continued From page 3 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure the care and maintenance of 1 of 1 rolling fire doors was in accordance with NFPA 80. NFPA 80, 1999 Edition, the Standard for Fire Doors and Fire Windows, Section 15-2.4.3 requires all horizontal or vertical sliding and rolling fire doors to be inspected and tested annually to check for proper operation and full closure. Resetting of the release mechanism shall be done in accordance with the manufacturer's instructions. A written record shall be maintained and shall be made available to the authority having jurisdiction. This deficient practice could affect any resident, staff or visitor in the main dining room. Findings include: Based on observation with the Maintenance Director on 02/08/11 at 1:30 p.m., there was a rolling fire door protecting the opening from the kitchen to the main dining room. Based on interview with the Maintenance Director at the time of observation, there was no documentation of an annual inspection to ensure proper operation and full closure of the rolling fire door. 3.1-19(b)	K 130	K 130 1. The identified rolling door was inspected.. And will be replaced before March 23rd. (see attached document) 2. There are no other rolling doors in the facility 3. The door will be inspected to be in working order by the maintenance director or designees with monthly fire inspections. It will be inspected annually by an outside vendor. 4. Results will be brought to QA monthly for 3 months and quarterly thereafter for tracking and trending. 5. March 23rd , 2011	
K 144 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.	K 144		

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K 144	Continued From page 4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure 1 of 1 emergency generators was equipped with a remote manual stop. LSC 7.9.2.3 requires emergency generators providing power to emergency lighting systems shall be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 1999 edition, 3-5.5.6 requires Level I installations shall have a remote manual stop station of a type similar to a break-glass station located outside the room housing the prime mover. NFPA 37, Standard for the Installation and Use of Stationary Combustion Engines and Gas Turbines, 1998 Edition, at 8-2.2(c) requires engines of 100 horsepower or more have provision for shutting down the engine at the engine and from a remote location. This deficient practice could affect all occupants. Findings include: Based on observation with the Maintenance Director on 02/08/11 during a tour of the facility from 12:05 p.m. to 2:00 p.m., the facility did not have a remote manual stop for the emergency generator. Based on an interview with the Maintenance Director at 12:05 p.m., the generator was installed in 2006. 3-1.19(b)	K 144	K 144 1. A remote stop was installed. 2. There are no other generators affected 3. This stop will be tested quarterly with the generator testing for proper function. 4. Results will be brought to QA monthly for 3 months and quarterly thereafter for tracking and trending. 5. March 10th, 2011	